DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long-Term Care Residents Protection

DHSS - DHCQ
263 Chapman Road, Ste 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Complete Care at Brackenville LLC **DATE SURVEY COMPLETED:** March 5, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health & Social Services, Division of Health Care Quality. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 03/02/26 – 03/05/26 Survey Census: 100 Sample Size: 40 Supplemental Residents: 8	Cross Reference plan of correction for deficiencies received during Annual/Complaint survey ending 3-5-2026 for F-tags 558, 610, 685, 686, 695 and 880	April 15, 2026
3201	**Regulations for Skilled and Intermediate Care Nursing Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed March 5, 2026: cross refer: F558, F610, F685, F686, F695 and F880.		

Provider's Signature _____ Title Administrator Date 3/18/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085042	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BRACKENVILLE LLC	100 ST. CLAIRE DRIVE , HOCKESSIN, Delaware, 19707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments A Recertification Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of State of Delaware, Department of Health & Social Services, Division of Health Care Quality from 03/02/26 to 03/05/26. The facility was found to be in compliance with 42 CFR 483.73.	E0000		03/17/2026
F0000	INITIAL COMMENTS A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health & Social Services, Division of Health Care Quality. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 03/02/26 – 03/05/26 Survey Census: 100 Sample Size: 40 Supplemental Residents: 8	F0000		03/17/2026
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure accommodation of needs for two of two residents (Resident (R) 71 and R5) in the sample of 40. Specifically, the facility failed to address necessary wheelchair repairs for R71 and did not provide R5 with access to a functioning call light. This created a potential risk for resident injury.	F0558	R71 resident's wheelchair was immediately assessed, and the armrests were replaced on 3/4/2026. The back lumbar support was replaced by the R71's family. R5's call light was immediately reconnected, tested, and confirmed to be functioning properly to ensure access to the call light Current residents who utilize wheelchairs and current residents who require access to a call light system to communicate needs (which is the entire resident population) have the potential to be affected by the deficient practice. Director of Nursing/designee will conduct an initial audit of current resident wheelchairs to ensure they are in good repair and meet the resident's needs. The Maintenance Director/designee will conduct an initial audit of all resident rooms to ensure call lights are present, plugged in, accessible and functioning properly. Any identified concerns will be immediately corrected, and work orders will be	04/15/2026

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F0558 SS = D	Continued from page 1 Findings include: 1. Review of R71's electronic medical record (EMR) titled "Face Sheet," located under the "Profile" tab, indicated an admission date of 10/25/24 with diagnoses of traumatic brain injury and quadriplegia. Review of R71's EMR titled "Care Plan," located under the "Care Plan" tab, dated 10/28/24, indicated that R71 was at risk for skin integrity due to fragile skin. Review of R71's EMR quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 12/14/25 indicated the staff were unable to determine a "Brief Interview for Mental Status (BIMS)" score. R71 was dependent on all activities of daily living from staff. During an observation on 03/02/26 at 11:52 AM, R71 was seated in his room in a customized, adapted wheelchair (tilt in space). The resident's bilateral wheelchair arms were cracked. The right-side arm rest had a large peeled opened area which exposed the cushion underneath the upholstery. The left side arm rest had multiple cracks. The concave back, attached to the back of the wheelchair, provided lumbar support. The left side of the concave cushion had an open area, which exposed the cushion underneath the upholstery. During an observation on 03/04/26 at 10:30 AM, R71 was in an activity. The bilateral arm rests were still in disrepair and so was the concave back support. During an interview on 03/04/26 at 12:15 PM, the Maintenance Director (MD) 2 stated that arm rests could be easily replaced on a resident's wheelchair, but he was unsure if he could repair the concave supportive device attached to the back of the resident's wheelchair. During an interview on 03/04/2026 at 3:38 PM, the Director of Nursing (DON) stated that the process was to inform maintenance, who would then repair the resident's wheelchair. The Administrator was present during this interview and stated that R71 owned the wheelchair, or even if the wheelchair was donated, this was considered a medical device, and the facility was not responsible for the repairs of the wheelchair. MD2 stated that there were no work orders in TELS (a web-based work order system). Review of the facility's policy titled "Accommodation of Needs" dated 03/13/23 indicated, " . . . The facility will treat each resident with respect and dignity and will evaluate and make reasonable	F0558	Continued from page 1 entered into the TELS system as indicated Root Cause: Was identified as a gap in staff timely reporting wheelchair repair needs through the TELS work order system and lack of consistent verification to ensure call lights remain plugged in and accessible to residents. Director of Nursing/designee will provide re-education to current staff on ensuring call lights remain plugged in, accessible and functioning prior to leaving the room and on the requirement to report all equipment concerns including wheelchair repairs through the TELS work order system immediately upon identification. The facility will implement a system change in which the maintenance director/designee will conduct monthly routine audits to observe all wheelchairs currently in use by residents for proper functioning and identify any needed maintenance. Regional Vice President will provide re-education to the Administrator and Director of Nursing related to maintaining resident equipment regardless of ownership to ensure resident safety and accommodation of needs. The Director of Nursing/designee will conduct random audits of 20% of residents who utilize wheelchairs to ensure wheelchairs are in good repair. The Director of Nursing or Designee will test a minimum of 20 resident call lights weekly on a random basis across all shifts and weekends to ensure each call light is activated, auditable and/visible and accessible to the resident. Audits will occur daily x 3 days or until 100% compliance is achieved, then weekly x 3 weeks or until 100% compliance is achieved then monthly x 2 months or until 100% compliance is achieved. Random audits will be scheduled in a way to ensure all call light systems in the facility are evaluated during the monitoring period. Results of the audits will be presented monthly by the administrator or designee for 3 months to the quality assurance performance improvement committee for further evaluation/recommendations and sustainability of the plan.	

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F0558 SS = D	Continued from page 2 accommodations for the individual needs and preferences of a resident, except when the health and safety of the individual or other residents would be endangered . . . " 2. Review of R5's "Face Sheet," located in the electronic medical records (EMR) under the "Profile" tab, revealed an admission date of 10/17/25 with the following diagnoses: myocardial infarction (heart attack) type 2, atypical atrial flutter (heart arrythmia), unspecified dementia, and reflux disease. Review of R5's quarterly "MDS" with an ARD date of 02/17/26, located in the "MDS" tab in the EMR, revealed R5 had a "BIMS" score of 11 out of 15, which indicated R5 had moderate cognitive impairment. Observation and interview on 03/02/26 at 4:43 PM revealed that R5 was visiting with a family friend in her room. During the observation, the call light was noted to be disconnected; the end of the cord that must be inserted into the wall for proper function was not inserted. Both the resident and the family friend confirmed the call light cord was not inserted into the wall. Interview with MD2 on 03/03/25 at 3:02 PM revealed call lights were randomly checked for function weekly. R5's call light system was repaired in 2020 and has had no other issues. Observation on 03/03/26 at 3:46 PM, R5's call light remained disconnected from the wall. Interview and observation on 03/03/26 at 3:55 PM with Certified Nurse Aide (CNA) 4 stated that call lights are used to alert staff that residents need assistance. CNA4 went to R5's room and confirmed the call light was not plugged into the wall. CNA4 proceeded to plug in the call light, which activated the alert sound as well as the light above the door, confirming the system was working properly. Interview and observation on 03/04/25 at 11:40 AM with MD2 confirmed R5's call light was unplugged. MD2 shared that he expected all call lights to remain plugged into the electrical socket. Interview with the Director of Nursing (DON) on 03/05/26 at 11:19 AM stated the expectation that all call lights would remain plugged into the electrical socket and were never unplugged from the wall socket.	F0558		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F0558 SS = D	Continued from page 3 Review of the facility's policy titled, "Call Lights: Accessibility and Timely Response," revised 03/14/23, revealed, "1. All staff will be educated on the proper use of the resident call system, including how the system works and ensuring resident access to the call light . . . 9. Ensure the call system alerts staff members directly or goes to a centralized staff work area . . . "	F0558		
F0610 SS = E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and policy review, the facility failed to thoroughly investigate allegations of abuse for four residents (Resident (R) 59, R88, R97, and R106) out of nine residents reviewed for abuse in a total sample of 40. This failure placed residents at risk of further abuse and a diminished quality of life. Findings include: 1. Review of the "Admission Record," located in the "Profile" tab of the electronic medical record (EMR), revealed that R59 was admitted to the facility on 05/09/25 with diagnoses that included hemiplegia/hemiparesis (paralysis on one side of the body) following a cerebral infarct (stroke) and major depressive disorder.	F0610	Residents R59, R88, R97 and R106 had their investigations reviewed. All identified allegations were re-investigated to include resident interviews, staff interviews, and review of relevant documentation to ensure thorough investigations were completed. Any missing components of the investigations were addressed immediately, including additional interviews, assessment, and documentation to support findings. Current residents who may voice grievances or allegations of abuse have the potential to be affected by the deficient practice. The Director of Nursing/designee will conduct an initial audit of all abuse and grievance investigations from the last 30 days to ensure investigations were thorough, including interviews with all applicable parties. Any identified concerns will be corrected immediately. Root Cause: Was identified as an inconsistent follow-through in completing investigations, including not interviewing all individuals who may have had knowledge of the allegation and not fully documenting all required components of the investigation. Administrator/designee will provide re-education to current nursing leadership (director of nursing, unit managers, supervisors, NPE/IP,ADON) social services, and department heads on abuse, neglect and resident rights policy with a focus on conducting thorough investigations which include interviewing other residents who may have knowledge of the allegation, completing timely physical and psychosocial assessments and ensuring all findings are documented. The facility will implement an investigation checklist tool and it will be utilized for all reportable incidents to ensure all required components for conducting a thorough investigation are completed. The regional clinical consultant or designee will provide re-education to the Director of Nursing on risk management principles to ensure regulatory compliance and oversight responsibilities to ensure investigations are thorough, timely, and meet regulatory requirements with a focus on ensuring all interviews/statements are being obtained from any individuals who may have knowledge of the allegation. RVP or designee will provide education to NHA and DON on conducting thorough investigations	04/15/2026

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F0610 SS = E	Continued from page 4 Review of the quarterly "Minimum Data Set (MDS)," located in the "MDS" tab of the EMR with an Assessment Reference Date (ARD) of 02/14/26, revealed R59 had a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15, which indicated R59 was cognitive intact. Review of the facility's investigation related to a 08/16/25 report of verbal abuse revealed R59 had slid to the floor when Certified Nurse Aide (CNA) 5 was assisting R59 back to bed. CNA5 called for assistance, and several CNAs came to assist. R59 asked for the Hoyer lift to get up, and CNA2 said he could get himself up. According to the report, R59 became angry and started cursing and told CNA2 to leave his room. CNA2 then told R59 that it wasn't his room; they then began bickering with each other. CNA2 did not leave R59's room until she was told to leave by the Licensed Practical Nurse (LPN) present. The investigation, provided by the facility, did not contain any resident interviews outside of R59. During an interview on 03/04/26 at 3:30 PM, R59 reported that he did not get along with CNA2, and he didn't think many people did. During an interview on 03/05/26 at 10:35 AM, the Director of Nursing (DON) was asked if she had any documentation to show that she had spoken to other residents on the unit and if they had experienced any verbal abuse by CNA2 and what their response was. The DON stated, " I don't remember if I interviewed other residents, but if not in the folder, no. I will double check." No other interviews were located. 2. Review of the "Admission Record," located in the "Profile" tab of the EMR, revealed R88 was admitted to the facility on 10/04/24 with diagnoses that included rheumatoid arthritis, hypertension, and peripheral vascular disease. Review of the quarterly "MDS," located in the "MDS" tab of the EMR with an ARD of 02/03/26, revealed R88 had a " BIMS" score of 14 out of 15, which indicated R88 was cognitively intact. Review of the facility's investigation of a report of verbal abuse on 02/04/26 revealed that R88's roommate was relocated to another room due to the roommate becoming aggressive with R88. On the day the roommate was moved, the roommate's daughter came to R88's room and cursed R88 out. R88 reported the incident to her son, and he reported it to the social worker. The file contained no interviews with other residents outside of	F0610	Continued from page 4 which include interviewing other residents who may have knowledge of the allegation, complete timely physical and psychosocial assessments and ensuring all findings are documented. The Regional Clinical Consultant/designee will conduct audits of all abuse investigations to ensure investigations are thorough, including all required interviews, assessments, and documentation. Audits will occur daily x 3 days or until 100% compliance is achieved then weekly x 4 weeks or until 100% compliance is achieved then monthly x 2 months or until 100% compliance is achieved. Results of the audits will be presented monthly by the administrator or designee for 3 months to the quality assurance performance improvement committee for further evaluation or recommendations and sustainability of the plan.	

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F0610 SS = E	Continued from page 5 R88. During an interview on 03/04/26 at 10:30 AM, R88 reported that she had never been so scared in her life. "The lady was so angry, called me a F—ing bitch and said I was going to hell." During an interview on 03/05/26 at 10:35 AM, the DON was asked if she had any documentation to show that she had spoken to other residents on the unit and if they had experienced any verbal abuse by this family member. The DON stated, "No. I didn't think it was necessary because this family member always sits at her mother's bedside, and her anger was directed at [R88]. In hindsight I probably should have." 3. Review of R97's "Admission Record," dated 03/05/26 and found in the EMR under the "Profile" tab, revealed R97 was admitted to the facility on 05/28/25. The resident's diagnoses included type 2 diabetes and epilepsy. Review of R97's quarterly "MDS" with an ARD of 02/06/25, found in the EMR under the "MDS" tab, indicated a "BIMS" score of 15 out of 15, which indicated the resident was cognitively intact. Review of R97's "Progress Notes," dated 06/18/25 and found in the EMR under the "Notes" tab, revealed "Resident's daughter reported that her mother told her that a male CNA wearing a red shirt was too rough with her and that he was upset with her for having to change her linens." Review of the facility's investigation related to the 06/18/25 report of potential staff to resident abuse revealed an incomplete investigation. Review of the investigation revealed R97 had been interviewed as part of the investigation; however, no additional interviewable residents residing in the same area of the facility and/or with potential knowledge of the incident were interviewed. 4. Review of R106's "Admission Record," dated 03/05/26 and found in the EMR under the "Profile" tab, revealed the resident was admitted to the facility on 06/12/22. The resident's diagnoses included type 2 diabetes and heart disease. The resident was discharged from the facility on 08/03/25. Review of R106's quarterly "MDS" with an ARD of 05/09/25, found in the EMR under the "MDS" tab, indicated a "BIMS" score of 15 out of 15, which indicated the resident was cognitively intact.	F0610		

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F0610 SS = E	Continued from page 6 Review of R106's comprehensive record revealed nothing in the progress notes or anywhere else in the record to indicate an allegation of potential abuse. Review of the facility's investigation documentation related to a 07/26/25 allegation of potential abuse by R106 revealed the resident reported a staff member entered her room and told the resident she was a poor excuse for a human being and refused to assist her with changing her brief. The investigation documentation revealed an incomplete investigation into the allegation of abuse. There were no additional residents or staff members interviewed related to the allegation, R106 was not physically and psychosocially assessed related to the allegation in a timely manner, and there was no facility review of the employee record of the staff member accused of being potentially abusive toward R106 as part of the investigation During an interview with the Administrator and DON on 03/05/26 at 12:19 PM, both confirmed the investigation into R106's allegation of potential abuse had not been thoroughly investigated (to include a thorough assessment of the resident, additional resident and staff interviews related to the allegation, and a facility review of the accused staff member's employee file). Both stated their expectation was that any allegation of potential abuse should be thoroughly investigated according to facility policy. Review of the facility's policy titled, "Abuse, Neglect and Exploitation," reviewed/revised 11/24 revealed, "An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. Written procedures for investigations include: . . . Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations."	F0610		
F0685 SS = D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and	F0685	Resident R97 received her hearing aids on 3/17/2026. Follow-up was completed to ensure the resident can utilize the hearing aids appropriately. R97's care plan was reviewed and updated to reflect hearing needs and interventions Current residents who have identified hearing needs have the potential to be affected by the deficient practice. The Director of Nursing/designee will conduct and audit all hearing consults back to January 1, 2026, to determine if there were any other residents requiring follow-up for hearing aids and to identify any outstanding ENT/audiology orders. Any identified	04/15/2026

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F0685 SS = D	Continued from page 7 §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff and resident interviews, and policy review, the facility failed to ensure hearing services were provided for one of one resident (Resident (R) 97 reviewed for vision and hearing services. The facility's failure to ensure the provision of timely hearing services had the potential to negatively impact R97's ability to effectively communicate. A total of 40 residents were reviewed in the sample. Findings include: Review of R97's "Admission Record," dated 03/05/26 and found in the electronic medical record (EMR) under the "Profile" tab, revealed R97 was admitted to the facility on 05/28/25. The resident's diagnoses included type 2 diabetes and epilepsy. Review of R97's "Audiology Consultation Report," dated 09/04/25 and found in the EMR under the "Miscellaneous" tab, revealed the resident had hearing loss and indicated the resident was in need of, and agreed to, a hearing aid evaluation for an assistive hearing device. Review of R97's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 02/06/25, indicated a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15, which indicated the resident was cognitively intact. Review of R97's care plan, dated 02/06/26 and found in the EMR under the "Care Plan" tab, revealed no care plan to address the resident's hearing needs. Review of R97's comprehensive record revealed nothing to indicate a referral had been made for the resident to have a hearing aid evaluation. During an interview with R97 on 03/02/26 at 2:45 PM, she stated she thought hearing aids were supposed to have been ordered in October of 2025, but she still did not have them. She stated she needed the hearing aids to hear appropriately.	F0685	Continued from page 7 concerns will be addressed immediately. Root Cause: Was identified as a lapse in follow-up and communication as hearing consults were sent to a former Social Services Director's email that was no longer being monitored resulting in delays in obtaining hearing aids. The Director of Nursing/designee will provide re-education to current social services and nursing leadership (unit managers, supervisors, ADON and NPE/IP) on timely follow-up for residents identified as needing hearing services including ensuring referrals are completed, services are obtained and follow-up is documented. The facility implemented a process to ensure all communication from the hearing vendor is shared with the interdisciplinary team in the future via email communication from the hearing vendor. This will include the Director of Nursing, Assistant Director of Nursing, Administrator, Unit Managers, and Social Services Director. The Assistant Director of Nursing or designee will have the final responsibility to ensure follow through email communication from the hearing vendor. The facility also collaborated with the hearing vendor to review the step-by-step process for obtaining hearing aids to ensure timely coordination of services. 4. The Director of Nursing/designee will conduct audits of all hearing and audiology consults and orders to ensure timely follow-up, completion of services and appropriate documentation. Audits will occur daily x 3 days or until 100% compliance is achieved then weekly x 4 weeks or until 100% compliance is achieved then monthly x 2 months or until 100% compliance is achieved. Results of the audits will be presented monthly by the administrator or designee for 3 months to the quality assurance performance improvement committee for further evaluation/recommendations and sustainability of the plan.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085042	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BRACKENVILLE LLC	100 ST. CLAIRE DRIVE , HOCKESSIN, Delaware, 19707

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F0685 SS = D	Continued from page 8 During an interview with the Social Services Director (SSD) on 03/04/26 at 12:15 PM, she indicated if a resident were having hearing concerns, she would notify the Director of Nursing (DON), and the DON would then generate a referral to obtain the hearing aids. The SSD confirmed she was unable to locate anything in R97's record to indicate follow-up after the 09/04/25 recommendation for R97 to acquire hearing aids. During an interview with the DON on 03/05/26 at 3:00 PM, she stated it was the responsibility of the Social Services Department to generate referrals for hearing and vision services. During an interview with the Administrator on 03/05/26 at 11:11 AM, he confirmed the facility should have followed up with the 09/04/25 recommendation for R97 to be evaluated for hearing aids and stated, "Obviously a resident who needs hearing aids should not go six months without them." The facility's "Hearing and Vision Services Policy," most recently dated 04/05/23, revealed, "It is the policy of this facility that all residents have access to hearing and vision services and receive adaptive equipment as indicated" and "Employee should refer any identified need for hearing or vision services/appliances to the social worker/social services designee" and "Once vision or hearing services have been identified, the social worker/social services designee will assist the resident by making appointments and arranging for transportation" and "Assistive devices to maintain hearing include, but are not limited to, hearing aids and amplifiers."	F0685		
F0686 SS = E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary	F0686	Upon identification, R5, R48 and R85's low air loss mattress was adjusted to align the manufacturer's recommended setting based on the resident's weight. R5, R48, and R85's skin was assessed with no further skin breakdown noted. Current residents utilizing low air loss mattresses have the potential to be affected by the deficient practice. ADON/designee conducted an initial audit on 3/16/2026 of those residents with low air loss mattresses to ensure the settings are set per the manufacture guidelines by the resident's weight. Any discrepancies were corrected immediately. Root Cause: Identified the need for re-education to current licensed nursing staff regarding how to determine mattress inflation settings based on the resident's weight. The facility has implemented a new	04/15/2026

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F0686 SS = E	Continued from page 9 treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record review, review of facility policies, and review of the manufacturer's manual, the facility failed to ensure pressure relieving air mattresses were correctly set according to the manufacturer's guidelines and residents' weights for three of five residents (Residents (R) 5, R48, and R85) reviewed for pressure ulcers out of a total sample of 40 residents. This failure placed residents at risk for skin breakdown, delayed wound healing, pain, infection, and potentially avoidable complications. 1. Review of R5's "Face Sheet," located in the electronic medical records (EMR) under the "Profile" tab, revealed an admission date of 10/17/25 with the following diagnoses: myocardial infarction (heart attack) type 2, atypical atrial flutter (heart arrythmia), unspecified dementia, and reflux disease. Review of R5's revised 01/15/26 "Care Plan," located in the EMR under the "Care Plan" tab, revealed "[R5] has a pressure ulcer to her sacrum and left buttock." Interventions included following the manufacturer's recommendation for proper function of the air mattress. Review of R5's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 02/17/26, located in the "MDS" tab in the EMR, revealed R5 had a "Brief Interview for Mental Status (BIMS)" score of 11 out of 15, which indicated R5 had moderate cognitive impairment. Further review revealed that R5 was admitted with one stage three pressure ulcer and one stage four pressure ulcer. Review of R5's weight, located under the "Weight/Vitals" tab in the EMR, revealed on 03/03/25 that R5 weighed 115.8 pounds (lbs). Observation on 03/03/26 at 3:46 PM, R5's "Proactive Air Mattress" weight dial, which could be dialed to weights between 80 and 350 pounds, was set at 80 lbs. Observation on 03/03/26 at 3:55 PM with Certified Nurse Aide (CNA) 4 confirmed R5's pressure relieving mattress was set at 80 lbs. Observation on 03/04/26 at 11:40 AM with the Maintenance Director (MD) 2 confirmed the air mattress	F0686	Continued from page 9 process to ensure low air loss mattresses are set correctly based on each resident's weight. All mattress units are now clearly marked to show the correct setting for each resident, making it easy for staff to set and verify the proper level. A physician's order has been added to the medication administration record to ensure the mattress setting continues to match the resident's weight. Licensed nurses are responsible for reviewing the resident's weight and confirming the mattress is set correctly. Director of Nursing/designee will educate current licensed nurses, nursing assistants and rehab staff on this process, including how to use marked settings and the importance of keeping the mattress at the correct therapeutic settings. Education will also include the static setting, explaining that it may be used temporarily during care but must be turned off and returned to the normal setting right after care is completed. Staff will be instructed to report any concerns with mattress settings to a nurse right away. This education will be included in new hire orientation and ongoing annual training. This process was put in place to Ensure the mattress are set at a therapeutic inflation based on residents weight for wound healing and prevention of development of new wounds. DON/designee will conduct audits of current residents utilizing low air loss mattresses to ensure the bed setting reflects the resident's current documented weight. These audits will occur daily x 3 days or until 100% compliance is achieved, then weekly x 3 weeks or until 100% compliance is achieved, then monthly x 3 months or until 100% compliance is achieved. Results of all audits will be presented monthly by administrator or designee for three months to the quality assurance performance improvement committee for further evaluation, recommendations, and sustainability of plan.	

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F0686 SS = E	Continued from page 10 was set at 80 lbs. Observation and interview conducted on 03/04/26 at 11:47 AM with Registered Nurse (RN) 1 indicated that nurses checked the air mattresses every shift and ensured the settings were adjusted according to the manufacture's recommendations and the resident's weight to maintain proper inflation and support the healing process. During this same time, RN1 confirmed that R5's air mattress was set at 80 lbs. When updated that R5's current weight was 115 lbs, RN1 stated, "The weight is set too low." 2. Review of R48's "Face Sheet," located in the EMR under the "Profile" tab, revealed an admission date of 09/29/24 with the following diagnoses: unspecified cord compression, spinal stenosis, hypertension, and type 2 diabetes. Review of R48's "Care Plan," located in the EMR under the "Care Plan" tab, revision date of 10/13/24, revealed R48 "is at risk for skin breakdown related to ambulatory dysfunction and decreased activity, bowel incontinence . . . " The care plan further indicated under interventions that R48 will have a therapeutic mattress. Review of R48's quarterly "MDS" with an ARD of 10/01/26, located in the EMR under the "MDS" tab, revealed R48's "BIMS" score was 14 out of 15, which indicated he was cognitively intact. Interview and observation on 03/02/26 at 2:16 PM revealed R48's air mattress was set at 240 lbs. R48 stated that his current weight was 193 lbs. R48 continued to share that he had been dealing with pressure ulcers and currently had a pressure ulcer on his coccyx. During an interview on 03/04/26 at 1:25 PM, R48 was in his room and stated that a facility staff member was in his room several minutes ago and readjusted his weight setting on the air mattress. Review of a "Nutritional Services" note, dated 03/05/26 and located in the EMR under the "Progress Notes" tab, indicated R48 weighed 213 lbs. 3. Review of R85's "Face Sheet," located in the EMR under the "Profile" tab, showed an admission date of 08/08/24 with diagnoses including dementia, type 2 diabetes, and adult failure to thrive. Review of R85's "MDS" with an ARD of 01/15/26, located	F0686		

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F0686 SS = E	Continued from page 11 in the EMR under the "MDS" tab, revealed he was at high risk for developing pressure ulcers. Review of R85's weight, located under the "Weight/Vitals" tab in the EMR, revealed on 01/12/26 R85 weight was 99.4 lbs. Interview on 03/04/26 at 11:40 AM with MD2 revealed he did not have the manufacturer's guide for the air mattresses and goes to the products website for guidance. Observation and interview conducted on 03/04/26 at 11:47 AM with RN1 indicated that nurses checked the air mattresses every shift and ensured the settings were adjusted according to the manufacture's recommendations and the resident's weight to maintain proper inflation and support the healing process. During this same time, RN1 went to R85's room and confirmed the resident's air mattress was set too high at 450lbs. During an interview on 03/05/26 at 11:19 AM, the Director of Nursing (DON) confirmed air mattresses should be set as close as possible to the resident's current weight. She shared her expectations that all air mattresses are set at the appropriate weight. Staff should readjust as the resident gains or loses weight to ensure proper healing and to reduce developing new skin issues. Review of facility policy titled "Use of Support Surfaces," revised 03/13/23, revealed "'Support surface' refers to specialized mattress . . . to manage pressure . . . " The policy further revealed, "Motor powered devices, or those requiring air, the licensed nurse will check each shift and prn [as needed] for proper functioning and /or inflation . . . alternating pressure or active support surface is a medical mattress designed to reduce and redistribute pressure on the skin especially for people who spend extended time in bed or have limited mobility . . . helps prevent and treat bed sores . . . " Under the heading "How to set up and use the mattress" it directed to "Adjust firmness . . . pumps have a dial based on patient weight . . . " Review of the "Proactek, Protect Aire 2000/3000 model" provided by the manufacturer at https://proactivemedical.com revealed under the "Operating Instructions," "Step 6 . . . Determine the patient's weight and set the control knob to that weight setting on the control unit."	F0686		
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning	F0695	R89's oxygen setup was immediately assessed by the unit	04/15/2026

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F0695 SS = D	Continued from page 12 CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations, staff interviews, and facility procedure review, the facility failed to ensure the routine provision of ordered respiratory services for one resident (Resident (R) 89) of two residents reviewed for respiratory services. The facility's failure created the potential for R89 to develop complications related to the ineffective administration of oxygen. A total of 40 residents were reviewed in the sample. Findings include: Review of R89's "Admission Record," dated 03/05/26 and found in the electronic medical record (EMR) under the "Profile" tab, revealed R97 was admitted to the facility on 02/04/26. The resident's diagnoses included chronic obstructive pulmonary disease (COPD) and pulmonary mycobacterial infection. Review of R89's physicians orders, found in the EMR under the "Orders" tab, revealed orders, with an original order date of 02/04/26, for the resident to receive oxygen three liters continuously per nasal cannula and for the resident's humidification bottle and oxygen tubing to be changed weekly on Wednesdays on the night shift. Review of R89's quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 02/11/26 and found in the EMR under the "MDS" tab, indicated a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15, which indicated the resident was cognitively intact. The assessment indicated R89 was receiving oxygen at the time of the assessment. Review of R89's "Medication and Treatment Administration Records (MARs/TARs)," found in the EMR under the "Orders" tab and dated 02/04/26 through 03/05/26, revealed nothing had been documented to	F0695	Continued from page 12 manager. A humidification bottle was applied per physician's order; oxygen tubing was replaced dated and labeled; orders were reviewed for accuracy and completeness. MAR/TAR documentation was corrected to reflect current treatment. Current residents with physician orders for oxygen therapy have the potential to be affected by the deficient practice. An audit was performed by the East Unit Manager on 3/4/26 of 100% of all residents receiving oxygen therapy to ensure presence of humidification when ordered/clinically indicated, tubing change dates and labeling, and MAR/TAR documentation was accurate and complete. Any identified issues were corrected immediately. Root Cause: Identified staff did not consistently follow the process for oxygen setup and documentation. Director of Nursing/designee will provide re-education to current licensed nurses on Oxygen administration requirements per facility procedure "changing disposable humidifier bottles procedure" which states humidifier bottles should be changed weekly and facilities procedure "stationary concentrators procedure" which states oxygen delivery devices and humidifiers should be changed weekly. The education will also include when humidification needs to be added to Oxygen delivery orders when the flow is greater than 2L/min. This education will be incorporated into the facilities new hire licensed nursing orientation to ensure ongoing compliance. Unit Mangers/designee will perform audits on current residents with oxygen delivery orders to ensure oxygen set up is labeled and dated, humidification in place as needed, and for complete accurate documentation. These audits will occur daily x 3 days or until 100% compliance is achieved, then weekly x 3 weeks or until 100% compliance is achieved, then monthly x 3 months or until 100% compliance is achieved. Results of all audits will be presented monthly by administrator or designee for three months to the quality assurance performance improvement committee for further evaluation, recommendations, and sustainability of plan.	

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F0695 SS = D	Continued from page 13 indicate the resident's humidification bottle and tubing had been changed on 02/11/26 or 02/25/26 per the physician's orders. During observations on 03/03/26 at 12:29 PM, 1:47 PM, and 3:01 PM and on 03/04/26 at 10: 08 AM, 10:57 AM and 2:39 PM, R89 was observed in bed in her room wearing her oxygen which was running at three liters per minute continuously. There was nothing on the resident's oxygen tubing to indicate the date it had been changed last. In addition, there was no humidification bottle attached to the resident's oxygen compressor. R89 was observed, along with the Interim Unit Manager, Registered Nurse (RN) 1 on 03/04/26 at 2:39 PM. RN1 confirmed there was nothing on R89's oxygen tubing to indicate when the tubing had last been changed, confirmed there was not a humidification bottle attached to the resident's oxygen concentrator as ordered, and confirmed there was nothing in the resident's record to confirm the tubing had been changed. RN1 stated oxygen being delivered at any rate above two liters per minute required humidification. During an interview with the Director of Nursing (DON) on 03/04/26 at 2:44 PM, she confirmed her expectation that all oxygen tubing/equipment was to be changed at least weekly, and this was to be documented on the MAR/TAR. The DON confirmed R89's oxygen should have been humidified. The facility's undated "Changing Disposable Humidifier Bottles Procedure" revealed, "Change humidifier bottles weekly or as per institution infection control policy." The facility's undated "Stationary Concentrators Procedure" revealed, "Oxygen delivery devices and humidifiers should be changed weekly."	F0695		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F0880	CNA3 was immediately re-educated on Enhanced Barrier Precautions and proper PPE use. R5's room signage was verified for accuracy and visibility. Staff caring for R5 were immediately reminded to follow enhanced barrier precautions including wearing gowns and gloves during high-contact care, which includes incontinent care. Current residents on Enhanced Barrier Precautions and staff have the potential to be affected by the deficient practice. The Director of Nursing/designee performed a facility wide audit on 02/24/26 to ensure appropriate signage was in place for those residents on Enhanced Barrier Precautions, care plans reflect EBP needs, PPE supplies are available and accessible and that staff on all shifts were observed during care to	04/15/2026

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F0880 SS = D	Continued from page 14 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F0880	Continued from page 14 ensure proper PPE use. Any identified issues were corrected immediately to reduce the risk of transmission to both residents and staff. Root Cause: Identified staff did not consistently follow enhanced barrier precautions during high contact care, including incontinent care. While staff had been trained, there was a lapse in applying appropriate PPE during high contact care. Indicating that there is a need for re-enforcement and monitoring. Director of Nursing/designee will provide re-education to current nursing staff on requirements for enhanced barrier precautions with a focus on required PPE during high contact care along with proper donning and doffing of PPE, and reinforcement of how residents on EBP are identified as it relates to door signage. Unit Managers/designee will conduct audits of 25% of residents on Enhanced Barrier Precautions selected randomly across all shifts including weekends and holidays to ensure proper PPE use during high contact care, presence of appropriate signage, staff adherence to EBP protocols These audits will occur daily x 3 days or until 100% compliance is achieved, then weekly x 3 weeks or until 100% compliance is achieved, then monthly x 3 months or until 100% compliance is achieved. Results of all audits will be presented monthly by administrator or designee for three months to the quality assurance performance improvement committee for further evaluation, recommendations, and sustainability of plan.	

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F0880 SS = D	Continued from page 15 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations, interviews, and review of the facility policies, the facility failed to ensure staff followed enhanced barrier precautions (EBP) and standard nursing precautions while providing care for one of one resident reviewed on EBP (Resident (R) 5). Specifically, a Certified Nurse Aide (CNA) failed to follow personal protective equipment (PPE) guidelines and wear a gown and gloves while performing incontinent care. This failure had the potential to cause further infection to the resident's wounds. Findings include: Review of R5's "Face Sheet," located in the electronic medical records (EMR) under the "Profile" tab, revealed an admission date of 10/17/25, with the following diagnoses: myocardial infarction (heart attack) type 2, atypical atrial flutter (heart arrythmia), unspecified dementia, and reflux disease. Review of R5's "Care Plan," revised 01/13/26 and located in the EMR under the "Care Plan" tab, revealed, "[R5] requires enhanced barrier precautions related to (wound, indwelling medical device, infection or colonization with MDRO)" It did not specify the reason for EBP but did document a skin opening requiring a dressing. Review of R5's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 02/17/26, located in the "MDS" tab in the EMR, revealed R5 had a "Brief Interview for Mental Status (BIMS)" score of 11 out of 15, which indicated R5 was moderately cognitively impaired. Further review revealed that R5 was admitted with one stage three pressure ulcer and one stage four pressure ulcer. Observation on 03/03/25 at 3:42 PM revealed an orange sign, "Enhanced Barrier Precautions" posted on the wall outside of R5's room with a "B" written in black. The	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085042	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BRACKENVILLE LLC	100 ST. CLAIRE DRIVE , HOCKESSIN, Delaware, 19707

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F0880 SS = D	Continued from page 16 sign read, "Stop: Enhanced Barrier Precautions, everyone must wash their hands including before entering and when leaving . . . wear gloves and a gown for the following high contact resident care activities- changing linens, providing hygiene, changing briefs, and dressing." During this same observation, CNA3 entered the resident's room and proceeded to provide incontinent care without donning a gown or gloves. Once R5's incontinent care was completed, CNA3 exited the room and asked CNA4 to retrieve some clean linen. Interview on 03/03/26 at 3:43 PM, CNA3 confirmed that R5 was on EBP and stated, "I should have put on my PPE." She further shared that EBP and Infection Control training was completed annually and as needed. During trainings staff were taught how to properly don and doff PPE along with what PPE was required based on residents' conditions. Interview on 03/03/26 at 3:55 PM with CNA4 confirmed R5 was on EBP. Interview on 03/04/26 at 11:47 AM with Registered Nurse (RN) 1 confirmed R5 was on EBP. RN1 stated all staff are trained on infection control to include how to identify residents on EBP. RN1 shared that the information about residents who are on EBP was listed on the Kardex, a sign posted at the resident's room, and in the EMR. Interview with the Director of Nursing (DON) on 03/05/26 at 11:19 AM revealed staff received infection control and EBP training upon hire, annually, and if needed during specific in-services. She stated she expected all staff to follow the infection control protocol and know how to identify residents on EBP and what PPE to use. Review of the facility's policy titled, "Enhanced Barrier Precautions," revised on 02/25/25, revealed "Enhanced Barrier precautions refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities."	F0880		